TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Doctors Hospital at Renaissance

Respondent Name
Ace American Insurance Co

MFDR Tracking Number
M4-17-3167-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
June 27, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "According to TWCC guidelines, Rule §134.403 states that the reimbursement calculation used for establishing the MAR shall be by applying the Medicare facility specific amount."

Amount in Dispute: $1,908.56

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Payment was previously made at the 200% OPPS rate per Texas Fee Schedule for CPT 63047, CPT 96365, CPT 96366 and CPT 90471."

Response Submitted by: Liberty Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 17 – 18, 2017	96360, 96365, 96366, 88304, 72100, G0237, 97116, 94770, 96375, 96374, 96372	$1,908.56	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the reimbursement guidelines for outpatient hospital services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - X936 – CPT or HCPC is required to determine if services are payable
   - U634 – Procedure code not separately payable under Medicare and or fee schedule guidelines
   - Z652 – Recommendation of payment has been based on a procedure code which best describes services rendered

- Z710 – The charge for this procedure exceeds the fee schedule allowance
- P300 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement
- MOPS – Services reduced to the outpatient perspective payment system
- MCMP – The final recommended reimbursement for CMS hospital outpatient APC composite is reflected on this line
- MJ1N – Recommended reimbursement is based on CMS Hospital outpatient status indicator J1: Comprehensive APC non-complexity adjustment
- 193 – CPT or HCPC is required to determine if services are payable
- W3 – CPT or HCPC is required to determine if services

Issues

1. What is the applicable rule that applies to reimbursement?

Findings

1. The requestor is seeking $1,908.56 for outpatient procedure rendered on January 17th and 18th, 2017.

   The insurance carrier denied disputed services with claim adjustment reason code U634 – "Procedure code not separately payable under Medicare and or fee schedule guidelines."

   The Division Rule that applies to Outpatient Hospital Services is found at 28 Texas Administrative Code §134.403. Section 134.403 (b) (3) and (d) states in pertinent part,

   > (b)(3) "Medicare payment policy" means reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare
   >
   > and
   >
   > (d) For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided.

   The Medicare Claims Processing Manual 100-04, Chapter 4, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf defines the following:

   - **How Payment Rates Are Set**, found at www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/HospitalOutpaysysfctsht.pdf,
     - *To account for geographic differences in input prices, the labor portion of the national unadjusted payment rate (60 percent) is further adjusted by the hospital wage index for the area where payment is being made. The remaining 40 percent is not adjusted.*

   - **Comprehensive APCs** - Comprehensive APCs provide a single payment for a primary service, and payment for all adjunctive services reported on the same claim is packaged into payment for the primary service. With few exceptions, all other services reported on a hospital outpatient claim in combination with the primary service are considered to be related to the delivery of the primary service and packaged into the single payment for the primary service.

   Review of the applicable Medicare Payment Policy finds Procedure Code 63047 has status indicator J1, which has the following definition:

   > *(1) Comprehensive APC payment based on OPPS comprehensive-specific payment criteria. Payment for all covered Part B services on the claim is packaged into a single payment for specific combinations of services, **except** services with OPPS SI=F, G, H, L and U; ambulance services; diagnostic and screening mammography; all preventive services; and certain Part B inpatient services.*

- Per Addendum B found at www.cms.hhs.gov procedure code 96360 has a status indicator of "S." Based on the above Medicare payment policy the service in dispute is packaged and separate payment is not recommended.

- Per Addendum B found at www.cms.hhs.gov procedure code 96365, billed January 18, 2017, has a status indicator of "S." Based on the above Medicare payment policy the service in dispute is packaged and separate payment is not recommended.

- Per Addendum B found at www.cms.hhs.gov procedure code 96366, billed January 18, 2017, has a status indicator of "S." Based on the above Medicare payment policy the service in dispute is packaged and separate payment is not recommended.

- Per Addendum B found at www.cms.hhs.gov procedure code 88304 has status indicator Q1, denoting STV-packaged codes; reimbursement for these services is packaged.

- Per Addendum B found at www.cms.hhs.gov Procedure code 72100 has status indicator Q1, denoting STV-packaged codes; reimbursement for these services is packaged.

- Per Addendum B found at www.cms.hhs.gov Procedure code G0237, billed January 18, 2017, has status indicator Q1, denoting STV-packaged codes; reimbursement for these services is packaged.

- Procedure code 97116, billed January 18, 2017, has a status indicator of "A." The Medicare Claims Processing Manual, Chapter 4, Section 10.2.3 found at www.cms.hhs.gov

  Claims reporting at least one J1 procedure code will package the following items and services that are not typically packaged under the OPPS:

  - *major OPPS procedure codes (status indicators P, S, T, V)*
  - *lower ranked comprehensive procedure codes (status indicator J1)*
  - *non-pass-through drugs and biologicals (status indicator K)*
  - *blood products (status indicator R)*
  - *DME (status indicator Y)*
  - *therapy services (HCPCS codes with status indicator A reported on therapy revenue centers)*

  Based on the above Medicare payment policy the service in dispute is packaged and separate payment is not recommended.

- Per Addendum B found at www.cms.hhs.gov procedure code 94770 has a status indicator of "S." Based on the above Medicare payment policy the service in dispute is packaged and separate payment is not recommended.

- Per Addendum B found at www.cms.hhs.gov procedure code 96375 has a status indicator of "S." Based on the above Medicare payment policy the service in dispute is packaged and separate payment is not recommended.

- Per Addendum B found at www.cms.hhs.gov procedure code 96374 has a status indicator of "S." Based on the above Medicare payment policy the service in dispute is packaged and separate payment is not recommended.

- Per Addendum B found at www.cms.hhs.gov procedure code 96372, billed January 18, 2017, has a status indicator of "S." Based on the above Medicare payment policy the service in dispute is packaged and separate payment is not recommended.

The Division finds the applicable Medicare payment policy packages all the services in dispute. No separate reimbursement is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		July 14, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.